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Recommended Citation

Debra T. Ballen, *Sleeper Issue in Health Care Reform: The Threat to Workers' Compensation*, 79 Cornell L. Rev. 1291 (1994)
Available at: <http://scholarship.law.cornell.edu/clr/vol79/iss6/1>

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THE SLEEPER ISSUE IN HEALTH CARE REFORM: THE THREAT TO WORKERS' COMPENSATION

Debra T. Ballen†

INTRODUCTION

The national health care reform debate raises important issues about the effect of federal legislation restructuring health care delivery on state workers' compensation systems. Workers' compensation is the oldest and most successful no-fault insurance system in the country, providing comprehensive medical benefits as well as cash income support, rehabilitation, and burial benefits for work-related injuries and illnesses.

The U.S. workers' compensation system is decentralized, with states having primary legislative, administrative, and operational responsibility for their individual programs. Over the years, there has been sporadic Congressional interest in enacting federal workers' compensation standards and even more limited support for establishing a broad-based national workers' compensation program. No such legislation has advanced very far in Congress on a stand-alone basis.

This strong state tradition is threatened by federal health care reform. The Clinton Administration initially favored "merging" the medical component of workers' compensation into the yet-to-be-defined federal health care system. While none of the Congressional bills go that far, provisions in several of the measures considered by Congress would interfere with state workers' compensation laws and set the stage for eventual merger. Even without a direct assault on workers' compensation, health care reform is likely to change the broader health care delivery system in ways that affect workers' compensation.

This Article examines the potential effects of national health care reform legislation on workers' compensation. It begins with an overview of existing state workers' compensation systems, focusing on issues that are central to the national health care reform debate. It next discusses political developments to date and analyzes the treatment of workers' compensation by the four major health care bills approved by Congressional committees. Finally, it considers the out-

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look for health care reform and the medical component of workers' compensation.

I

OVERVIEW OF THE WORKERS' COMPENSATION SYSTEM

A. History and Scope

Workers' compensation provides complete medical care for work-related injuries and illnesses without deductibles, copayments, or dollar or time limits. It also affords income support, rehabilitation, and burial benefits to eligible claimants or their surviving dependents. The system functions on a "no-fault" basis, and employers who provide statutorily prescribed benefits are released from further liability under the "exclusive remedy" doctrine.¹

The system was designed to address the growing number of work-related injuries incurred during the Industrial Revolution. Before workers' compensation, injured workers had to file lawsuits to receive compensation. A variety of common-law defenses protected employers from liability, but once plaintiffs overcame these defenses, employers faced the possibility of ruinous awards that were not covered by insurance.

While these principles have remained intact, many state workers' compensation systems have experienced unprecedented challenges over the past decade. Costs have risen due to a variety of factors—benefit increases, greater number of claims, increased incidence of litigation, and expansion of the scope of injury that the system is called upon to compensate. As a result of higher underlying costs, insurers have had high underwriting and operating losses, and employers have faced high costs for insurance premiums or self-insurance.

B. Medical Care Component

The medical care component of workers' compensation has also been a system cost driver. Medical care represents a large percentage of claim costs, accounting for about forty-five percent in 1992.² Between 1985 and 1990, workers' compensation medical expenditures per worker increased at an average rate of 12.5%, compared to average annual per capita growth of 8.7% for the broader health care sys-

¹ According to these principles, injured workers forgo the right to seek tort recoveries in exchange for guaranteed benefits, and employers agree to provide statutory benefits, without regard to fault, in exchange for their release from further liability.

² Insurance Services Office, Inc., *Health Care Costs in the Property/Casualty Insurance Industry 10* (Dec. 1993) (unpublished study, on file with author) [hereinafter *Health Care Costs*].

tem.³ Despite these increases, workers' compensation medical care still accounts for only a small part of the total U.S. health care system (less than three percent).⁴

Looking at the cost data, it is tempting to initially conclude that workers' compensation medical care is "out of control," thus justifying the inclusion of workers' compensation in health care reform. Such a conclusion, however, ignores the fact that workers' compensation differs in important aspects from other health care delivery systems. These distinguishing characteristics stem from workers' compensation's role as an alternative to the tort liability system.

First, unlike most other health care financing programs, the workers' compensation system requires employers and insurers to pay 100% of employee medical costs. Workers often have no direct incentive, and at times, no opportunity, to act as prudent purchasers of medical care. By contrast, employer-sponsored employee health benefit plans typically use financial incentives to encourage the selection of programs with managed care features, and to promote beneficiary compliance with managed care requirements.

Second, workers' compensation medical care is delivered as part of a broader disability benefit package, a substantial component of which involves indemnity payments for lost wages. Employers and insurers have an interest in managing claims in a manner that reduces overall payments—medical and indemnity. Thus, workers' compensation will provide expensive medical treatment if it is likely to accelerate recovery and return to work.

Third, subjective elements of the workers' compensation system encourage excessive use of medical services. Unlike health or government program coverage, where the individual has no economic incentive to continue medical treatment beyond its remedial value, an injured worker can use on-going medical care as evidence of the severity of a disability to justify benefit payments under the indemnity component of workers' compensation.

Fourth, about half of the state workers' compensation laws allow the employee to choose the medical care provider, thereby limiting the extent to which employers and insurers can furnish comprehensive managed care.⁵ In addition, many states still do not permit work-

³ CAROL A. TELLES, WORKERS COMPENSATION RESEARCH INSTITUTE, MEDICAL COST CONTAINMENT IN WORKERS' COMPENSATION: A NATIONAL INVENTORY, 1992-1993, at 4 (1993).

⁴ See Health Care Costs, *supra* note 2, at 3, 10.

⁵ States that allow employees to choose the medical care provider include: Alaska, Arizona, Connecticut, Delaware, Hawaii, Illinois, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New York, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Dakota, Texas, Washington, West Virginia, Wisconsin, and Wyoming.

ers' compensation to employ the same medical claims management techniques commonly used in other medical payment systems.

Notwithstanding these constraints, managed care in workers' compensation has grown over the past several years. A significant number of states have enacted legislation to improve fee schedules, authorize utilization review, permit the use by employers and insurers of certified managed care organizations, and encourage other medical cost containment techniques.⁶ Moreover, employers and insurers are finding new and innovative ways to tailor the principles of managed care to workers' compensation.⁷ Since many of these cost control initiatives have been implemented only recently, there is little published research documenting their impact. What evidence there is suggests a strong likelihood that efforts to promote managed care in workers' compensation are effective and consistent with the system's obligations to injured workers.

C. Relationship of Workers' Compensation to Health Reform Goals

Over the course of its eighty-year history, workers' compensation has been developed, administered, and refined by state legislatures, administrative agencies, and courts. As a result of this extensive state involvement, virtually every aspect of the system is highly regulated. Indeed, many of the difficult issues before Congress in the national health care reform debate have already been addressed by state workers' compensation systems. A brief description of the key components of workers' compensation suggests that including workers' compensation in health care reform is not likely to expand coverage, enhance benefits, improve regulatory oversight, or otherwise help system participants, as the following discussion indicates:

- *There is an employer mandate.* Employers generally are required to provide their employees with workers' compensation coverage. Federal employer's liability acts also provide substantial protection.
- *There are no employee premium payments or out of pocket costs.* Employers are required to fund 100% of their workers' compensation premium obligations. Employees make no contributions to insurance costs, nor do they pay deductibles or make copayments for care received.
- *Medical benefits are comprehensive.* Medical coverage under workers' compensation is broader than that provided by other health care

⁶ See Dan Wise, *The Promise and Peril of Managing Workers' Comp*, HMO MAGAZINE, Jan.-Feb. 1994, at 49.

⁷ See, e.g., INSURANCE RESEARCH COUNCIL, MEDICAL COST CONTAINMENT IN CASUALTY CLAIMS: TECHNIQUES USED BY AUTO, LIABILITY, AND WORKERS' COMPENSATION INSURERS (1991).

systems, including that contemplated by the various federal health care reform proposals. All reasonable and necessary medical care is covered, including long-term care and unlimited mental health services. There are no dollar or time limits.

- *Wage loss benefits are also provided.* Injured workers also receive monetary benefits to cover short- and long-term disability. Benefits are not subject to federal or state income tax.
- *States enforce legal protections for workers.* While most claims are paid quickly and without controversy, state administrative agencies are in place to settle disputes and prevent litigation.
- *Coverage is completely portable.* Employees who change jobs or retire remain fully covered under the system. There are generally no exclusions for preexisting conditions.
- *Coverage is available to all employers.* All states have "residual markets" (pools reinsured by insurance carriers) or state funds which guarantee coverage to all employers, including those with poor claims experience.
- *The cost burden is distributed equitably among employers.* Workers' compensation is one of the most heavily regulated forms of insurance. There are approximately 600 state-approved employment classifications and a state-regulated rating system designed to allocate costs among employers on an equitable basis.

II

NATIONAL HEALTH CARE REFORM: DEVELOPMENTS TO DATE

A. Merger of Workers' Compensation and National Health Care Coverage

Early in the development of the Clinton health care agenda, there was serious consideration given to proposals to "integrate" or "merge" workers' compensation medical care and financing into the new national health care system. Proponents of merger within the Administration seem to have been motivated by several assumptions: first, the belief that the unification of workers' compensation and health insurance would reduce administrative expenses; second, the hope that these savings could be used to offset the costs of employer mandates for health insurance and thus generate business support for the President's broader health care agenda; and third, a political philosophy premised on the notion that "bigger" health care reform is "better" health care reform.

However, the merged system proposal was widely criticized outside the White House. For example, the National Federation for Independent Business, which has led the charge against the proposed employer mandate for health insurance, polled its members on the workers' compensation merger question and found sixty-three percent voting in the negative, nineteen percent voting in the affirmative,

and eighteen percent undecided.⁸ Business owners quickly realized that "[s]hifting costs from one system to another does not make them go away."⁹ Moreover, none of the other health care reform proposals that were released while the Clinton plan was under development included any restructuring of state workers' compensation systems.

Lacking support for merging workers' compensation into a reformed health care system, the President instead proposed a more incremental process incorporated in Title X of the proposed Health Security Act. Proposed Title X would integrate the *delivery* but not the *financing* of occupational and nonoccupational medical care,¹⁰ and create a commission to study the possibility of full integration.¹¹ Title X is discussed in more detail in the next section, which focuses on congressional committee action.

B. Congressional Committee Action

As of this writing, four congressional committees have approved health care reform bills that differ in varying degrees from the Clinton Administration proposal. The House and Senate Majority Leaders are finalizing the packages they hope to send to their respective chambers for floor action. As is the case with many of the broader aspects of health care reform, each of the relevant Committees has taken a different approach to workers' compensation.

1. *House Education and Labor Committee Bill*¹²

Of the four committees with jurisdiction, the House Education and Labor Committee approved the most sweeping and, from the perspective of state workers' compensation systems, most destructive provisions. The Education and Labor Committee's Title X generally parallels that of the Clinton Administration bill.

With limited exceptions, injured employees would receive medical care from the same federally authorized health plan selected for their other health care needs, or from a state certified center of their

⁸ *The Burden of Escalating Workers' Compensation Costs on Small Business: Hearings Before the Comm. on Small Business, U.S. House of Representatives*, 103d Cong., 1st Sess. 147 (1993) (statement of Jon Egge, National Federation of Independent Business).

⁹ *Id.* at 10 (statement of J. Drew Hiatt, Executive Vice President and Director of Government Affairs for the National Business Owners Association). Mr. Hiatt also testified that "[t]he National Business Owners Association asked its members in an August 1993 survey . . . whether they would favor including the medical portion of workers' compensation in the administration's new health care reform program. The respondents strongly opposed the proposal." *Id.*

¹⁰ Health Security Act, Title X, Subtitle A, § 10002.

¹¹ *Id.* § 10201.

¹² H.R. 3600, 103d Cong., 2d Sess. (1994).

choosing.¹³ Insurers and employers would be prohibited from channeling injured workers to alternative providers or selecting managed care plans that provide more intensive treatment to speed return to work. The bill would preempt state "choice of provider" laws,¹⁴ about half of which now authorize employers to make the initial choice of provider and all of which grant employers a role in the management of claims.

The bill attempts to compensate for the absence of employer/insurer involvement in claims management through the use of fee schedules, certification standards, designated coordinators, and reporting requirements. For the most part, these controls would be of limited value and some could add new costs. For example, the requirement that health plans designate a workers' compensation "case manager"¹⁵ to coordinate care is likely to duplicate—and possibly disrpt—case management services that are now provided by insurers and employers. It also might impede effective communication between employers-insurers and the treating physician, leading to treatment delays and higher costs. It is unclear how the fee schedules would affect the charges imposed by existing state workers' compensation fee schedules, or whether they would include safeguards to prevent overuse.

The Education and Labor Committee bill also creates a commission to study the feasibility and appropriateness of transferring financial responsibility for workers' compensation medical benefits to the national health plans.¹⁶ If the commission recommends merger, legislation would be put on a "fast track," using trade agreement procedures intended to limit Congressional debate.¹⁷

2. *Senate Labor and Human Resources Committee Bill*¹⁸

Senate Labor and Human Resources Committee Chairman Edward Kennedy originally proposed a Title X that closely resembled President Clinton's workers' compensation provisions. During the markup, a Republican amendment to strike the title failed on a party line vote. Later in the session, the Committee adopted an amendment which scaled back the scope of the original language.

¹³ *Id.* § 10001(a). Exceptions would be made for, among others, injured workers needing emergency medical services and those who agree with their employer or insurer to obtain care through an alternative arrangement. *Id.* §§ 10001(a), 10001(b).

¹⁴ *Id.* § 10012(a).

¹⁵ *Id.* § 10001(c).

¹⁶ *Id.* § 10201.

¹⁷ The "fast track" authority was not part of the original Clinton bill but resulted from an amendment offered in Committee by Congressman George Miller (D-CA) and agreed to by a voice vote.

¹⁸ S. 2296, 103d Cong., 2d Sess. (1994).

The Labor and Human Resources Committee bill does not direct injured workers to generalized health plans or preempt state choice of provider laws. It does, however, require that providers who handle workers' compensation claims comply with various federal and state data reporting requirements that in the past have been applied only to employers and insurers.¹⁹ This raises concerns about duplicative or inconsistent reporting. Moreover, these requirements may represent an effort to legislate occupational disease notification requirements that Congress has rejected in the past.

This bill also retains the federal study commission to issue a recommendation on whether to transfer the financial responsibility for workers' compensation medical benefits to federal health plans and, if so, to provide a detailed implementation plan.²⁰ The panel would be more balanced, however, and the "fast track" authority that was amended to the House Education and Labor Committee bill is not found in the Senate version.

3. *House Ways and Means and Senate Finance Committee Bills*²¹

Neither the House Ways and Means Committee bill nor the Senate Finance Committee bill contains a workers' compensation title. The rationale for excluding workers' compensation seems to be both substantive and political. On the substantive side, exclusion of workers' compensation from the bills recognizes the on-going and productive nature of state involvement in workers' compensation. On the political side, these committees may have wished to avoid tangential and unnecessary political battles that might cloud the broader health care reform debate.

III ANALYSIS

The health care reform proposals summarized in the previous section represent three basic options for addressing workers' compensation: full integration, partial integration, and exclusion. Full integration clearly would be the most destructive to state workers' compensation systems, but partial integration—at least as embodied in Title X of the Clinton Administration and Education and Labor Committee bills—poses a serious threat as well. Excluding workers' compensation from health care reform also would pose problems if

¹⁹ *Id.* § 10000.

²⁰ *Id.* § 10003.

²¹ H.R. 3600, S. 2296, 103d Cong., 2d Sess. (1994).

the legislation is drafted in a manner that encourages claim or cost shifting.²²

A. Merger

In a fully "integrated" system, medical care for work-related injuries and illnesses would be among the benefits provided and financed by the national health care program. State workers' compensation systems would continue to define and oversee wage replacement benefits, resulting in disjunction between the provision of medical and indemnity benefits.

Although proponents of this approach claim that it would save money and eliminate bureaucracy, the reverse is more likely to be true. Workers' compensation provides intensive medical services often entailing many medical procedures per treatment and a high frequency of treatment. As a result, duration of care is longer under ordinary medical care coverage. According to one estimate, an increase of just twenty percent in the duration of disability would add \$10 billion to the annual cost of workers' compensation indemnity benefits.²³

Under an integrated system, workers' compensation would be subject to the same rating system as other health insurance—most likely, community rating in which all (or most) individuals within a given locality would be charged the same rates for a basic benefits package. Community rating would be a significant departure from the current workers' compensation rating system, which is designed to create strong financial incentives for employers to promote workplace safety by grouping employers according to the riskiness of specific occupations, and then adjusting rates according to each employer's individual history of loss.²⁴ To the extent that insurance costs would cease to be based on an employer's actual experience, safe employers would no longer benefit from their loss control efforts, and unsafe employers would enjoy lower costs. The result would be a reduction in workplace safety efforts. According to an American Insurance Association

²² Claim shifting occurs when a questionable claim is characterized as "work related" in order to qualify for the more comprehensive benefits and higher reimbursement levels of workers' compensation. Cost shifting occurs when providers charge higher fees for workers' compensation patients than for those who may be covered by price-constrained programs such as Medicare, Medicaid, and discounted managed care plans.

²³ *Health Security Act: Workers' Compensation Insurance, Auto Insurance and Transition Rules: Hearings on H.R. 3600 Before the House Subcomm. on Commerce, Consumer Protection, and Competitiveness of the House Comm. on Energy and Commerce*, 103d Cong., 2d Sess. (Feb. 1, 1994) (statement of Thomas Taylor, Chairman, Special Task Force on Health Care Reform and Auto Insurance, Alliance of American Insurers), available in LEXIS Legis Library, Cngtst File.

²⁴ The principal devices used for this purpose are the classification system and experience rating.

study, these changes would increase lost work time due to injury by approximately 11.5%.²⁵

A fully integrated system also could threaten the exclusive remedy doctrine. Merger could entail the application of cost sharing features, including employee deductibles, copayments, and shared insurance premiums, that would shift costs from employers to employees.²⁶ As a result, workers might seek recovery for costs that are currently financed by workers' compensation through tort actions against their employers. Whether the exclusive remedy doctrine could withstand such an assault remains to be seen. Even in the absence of employee cost-sharing requirements, a system that treats occupational injuries the same as nonoccupational injuries raises questions about whether injured workers would receive benefits commensurate with the exclusivity of workers' compensation benefit awards.

In addition to these problems, it appears that the administrative savings ascribed to a single system may fall short of the expected benefits.

First, proponents of the merger approach claim substantial savings would be realized by eliminating duplicate payments. However, a study of two large employers found that workers' compensation medical payments on claims also paid by health insurance totaled less than one half of one percent of total workers' compensation medical payments.²⁷ An insurance company report found that five percent of workers' compensation medical transactions involved duplicate payments.²⁸ Whichever figure one accepts, it is clear that the amount saved would be small.

Another assumption regarding integration is that an integrated system would reduce litigation because work relatedness would no longer be an issue in determining whether medical expenses are compensable. However, if the system merged medical benefits but retained separate workers' compensation indemnity benefits,²⁹ litigation

²⁵ DAVID APPEL ET AL., MILLIMAN & ROBERTSON, INC., WORKERS' COMPENSATION AND HEALTHCARE REFORM: AN ACTUARIAL AND ECONOMIC ANALYSIS OF TWO PROPOSALS 3 (Sept. 14, 1993) (on file with author).

²⁶ Workers' compensation currently provides comprehensive first-dollar and last-dollar coverage for all medical services.

²⁷ Taylor Dennen, William Mercer, Inc., Can Integration of Workers' Compensation and Health Benefits Programs Save Money? (unpublished paper, on file with author).

²⁸ WORKERS' COMPENSATION RESEARCH INST., TWENTY-FOUR-HOUR COVERAGE 49 (Richard A. Victor, ed., 1991) (quoting John Plis' comments during the Workers' Compensation Research Institute Annual Issues & Research Conference Panel Proceedings).

²⁹ None of the bills discussed herein appears directed at integrating the wage replacement features of workers' compensation with a new federal entitlement program. This approach has, however, been discussed in the descriptive literature on merged systems. See KEITH T. BATEMAN & CYNTHIA T. VELDMAN, ALLIANCE OF AMERICAN INSURERS, TWENTY-FOUR HOUR COVERAGE: AN ANALYSIS AND REPORT ABOUT CURRENT DEVELOPMENTS (1991).

of such disputes would continue. Moreover, for claims which involve both medical care and indemnity benefits, litigation would continue over degrees of disability and return to work status.

Finally, a merged system would take on many of the expenses now associated exclusively with workers' compensation. These include litigation costs, reporting requirements imposed by state agencies, and second injury funds.

B. Partial Integration

In theory, partial integration could take many forms, with varying consequences for workers' compensation. Some, such as the adoption of broadly successful managed care techniques by workers' compensation, could improve the quality of cost-effectiveness of workers' compensation medical care. However, the version of partial integration incorporated in Title X of the Clinton Administration and Education and Labor Committee bills would harm workers' compensation by reducing the use of managed care that is sensitive to the unique characteristics of workers' compensation. Given that the broader health care reform debate seems to be moving away from managed care,³⁰ it is unlikely that partial integration could help the workers' compensation system to control costs and speed recovery. It is more likely to involve preemption of state employer choice of physician and managed care laws.

C. Exclusion

Excluding workers' compensation from federal legislation should not be mistaken for maintaining the status quo. To the extent that health care reform changes the manner in which health care is delivered and financed, there are potential implications for workers' compensation—particularly with respect to the likelihood of claim or cost shifting.³¹ For example, efforts to squeeze more costs out of Medicare, Medicaid, and employee benefits plans would increase the likelihood of cost shifting to workers' compensation as providers seek to recover lost income by increasing revenue from sources outside the scope of price controls.³²

³⁰ The measure approved by the House Ways and Means Committee, for example, imposed new federal restrictions on managed care, such as requirements that networks accept "any willing provider." See H.R. 3600, 103d Cong. 1st Sess. § 1407 (1993).

³¹ See *supra* note 22.

³² The Ways and Means Committee bill, which includes fee schedules for an expanded Medicare program, attempts to address this problem by providing that fees for medical services which are covered by property-casualty insurance (including workers' compensation) shall not be less favorable than fees for similar services covered by the health plan in which an individual is enrolled.

The increased prevalence of HMOs and other capitated payment plans could also cause claim shifting. Recent research suggests that HMOs may be more inclined to classify injuries as work related to obtain revenue beyond the capitated payments received from members.³³ While this is a legitimate cause for concern, it should be noted that the growing dominance of HMOs is likely to continue even in the absence of federal legislation due to market pressure or state health care reform enactments.

IV OUTLOOK

In the volatile political atmosphere that characterizes the health care debate, even the most circumspect predictions are difficult. At the risk of being proven wrong even before this Article is published, I will attempt to make some modest political predictions in order to answer the question of how health care reform will affect workers' compensation.

First, the design of the health care system that emerges from Congress will determine whether it is even possible to integrate workers' compensation into the health system at large. It now appears unlikely that any legislation approved by Congress will include the controversial "employer mandate" for health insurance. Moreover, differences in the scope of benefits are likely to remain, such as no copayments or deductibles in workers' compensation, making it impracticable to combine the two systems.

In addition, while managed care has not received as much attention as the employer mandate and other "first tier" issues, it has important implications for workers' compensation as well. The extent to which federal legislation encourages or impedes the use of managed care by health plans will influence the further development of these techniques for workers' compensation. As of this writing, the outcome of this debate is uncertain.

Finally, in order to maintain the integrity of the current state-based system, workers' compensation must provide high quality, cost-effective care that hastens rehabilitation and return to work. When federal health care reform recedes from the air waves and the front page, the medical care component of workers' compensation must continue to be the focus of state legislative and regulatory attention if the system is to remain intact and fulfill its historic promise.

³³ See Richard T. Butler et al., *HMOs, Moral Hazard and Cost Shifting in Workers' Compensation* (Nov. 19, 1993) (unpublished paper prepared for the Twelfth Annual Seminar, *Economic Issues in Workers' Compensation*, Wharton School, University of Pennsylvania, on file with author).